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**'Reworking therapeutic landscapes: The spatiality of an "alternative" self-help group', *Social Science & Medicine*, 69, (2009) pp. 1827-1833**

Jennifer Laws, Durham University, UK

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## **Abstract**

Since Gesler first introduced the concept in 1992, the language of 'therapeutic landscapes' has attained a core position in the toolkit of health/place studies. Whilst many authors using the term acknowledge that therapeutic landscapes are often also spaces of contestation, few if any have extended this to incorporate a serious critique of therapy itself. In this article, I use the case study of an 'alternative' psychiatric survivor (self-help) group in the north of England to attempt just this. Based on a ten month period of ethnography, I engage with the *spaces* – meeting places and venues – occupied by the group, focusing on the dilapidated and reputedly dangerous city park where the group hosts its most regular meetings. Three qualities of these spaces were found to be particularly embraced by the group: spaces of agency and appropriation; a space in the world; and a non-technical relation with space. The article uses these three themes to explore how the unconventional spaces of the group are not mere products of marginality but a serious aspect of mobilising the dissident and 'anti-psychiatric' recovery sought by its members. Through attending to what the survivors' found helpful in the park, a more sensitive rendition of 'anti-psychiatry' as it relates to the group is developed. The therapeutic landscapes framework as put forward by Gesler retains currency in highlighting the importance of place to the processes and identity of the group. However, it is also suggested that the 'dissident topophilias' of the survivors express a critique of current therapeutic landscapes thinking, challenging the supposition that it is the planned, the pleasant and the professional that provide the best backdrops for recovery.

## **Introduction**

The therapeutic landscapes perspective, first introduced by Gesler in 1992, has today become a broad collection of approaches in social science and health studies which together explore the rich connectedness between healing and place (Gesler, 1992; Gesler, 2003; A. Williams, 2007). Traditional 'therapeutic landscapes' have included the restorative properties of spa towns, spiritual retreats and landscapes of natural beauty, yet more recently the term has also been applied to places expressly set aside for 'cure' or treatment such as hospitals and clinics (e.g., Curtis, Gesler, Fabian, Francis & Priebe, 2007; Kearns & Barnett, 1999). Underlying many of these approaches is an assumption that what is therapeutic in the natural context provides a good basis for clinical therapy

also. Whilst authors using the therapeutic landscapes construct have long wrestled with a lack of consensus in defining what kind of place is therapeutic (Andrews & Holmes, 2007; Curtis, Gesler, Priebe, & Francis, 2009), few if any have taken seriously the contested nature of *therapy* itself. In particular, the many and varied critical approaches to therapy (often associated with the ‘anti-psychiatry’ movement, which has also incorporated many critiques of talking therapies) are barely represented within the therapeutic landscapes literature. In this article, I use ethnographic data from an ‘alternative’ and politicised self-help network of mental health service-users and ex-service-users in the north of England to address this lacuna.

Located ideologically and geographically beyond the traditional spaces of care and service provision, the ‘survivor’ group (so-called due to its loose alignment with the ‘psychiatric survivor’ or ‘anti-psychiatry’ movement) is excellently positioned to begin the work of thinking critically about ‘therapy’ – not least because of the self-avowed ambivalence of its members towards institutionalised or professionalised forms of care and treatment. Two major threads or themes emerge in the argument which follows. The first embraces the therapeutic landscapes *method* (as an attentiveness to the healing qualities of place) to explore how a *spatial* reading of the survivor group provides a more nuanced understanding of some particular hostilities towards therapy and psychiatry. The latter works at unpicking the concept of ‘therapy’ within the therapeutic landscapes discourse. An important assertion here is, to the extent that therapy might be equated by some as a treatment or ‘cure’, members of the survivor group did *not* find the traditional landscapes of therapy (hospitals, clinics, therapy rooms.) therapeutic. A complementary thread tackles a second muddle; that ‘therapy’ might best be equated with what is comforting or comfortable (a potential sense of the adjective ‘therapeutic’, perhaps). Whilst this may come as no surprise to those who have undergone therapy or practiced it, both theoretical approaches to therapeutic landscapes and practical applications in designing spaces for therapy often appear to neglect this, in a point I develop throughout the article.

Within this debate, links are made with the growing body of research (e.g., Davidson, 2003; Knowles, 2000; Parr, 2008) that seeks to challenge what Faulkner and Thomas (2002) identify as an endemic bias towards top-down perspectives in mental health research. In this tradition, important strides have been taken to emphasise the lived and embodied subjectivities of people with mental health problems and to celebrate the capacity of psychiatric patients for self-determination. In cultivating this consciously ‘hopeful ontology’ (Conradson 2003, p.521), widespread anxieties in popular culture about mental health patients and ‘self-help’ are also challenged, be these visions of malignant narcissism (see David Fincher’s creation in the opening scenes of *Fight Club* for a parody) or fears about the unacceptable riskiness of unregulated patient-to-patient alliances such as the survivor group. Attending to the survivor group neither allays these concerns nor presents the viewpoints of its members as representative of the mental health service-user community. However, in listening to the members of the survivor group and documenting their ‘alternative’ landscapes of therapy, the ethnography gives testimony to the diversity of alternative recoveries and survivorships.

In the remainder of the paper, after introducing the survivor group and research methodology, I begin by demonstrating the shared importance of space to the development of psychiatry/psychotherapy and the alternative model of the survivors. I then explore in greater detail the ‘dissident’ connections or *topophilia* (literally, love of place – see Tuan, 1974) that the survivor group demonstrate towards their meeting places, and the oppositional relations these assume with traditional landscapes of psychiatry and psychotherapy. I conclude with some comments aimed at reuniting the apparently ‘mad’ preferences of the survivor group with a more ‘ordinary’ understanding of emotion and place, drawing on insights from the arts and humanities. Readers will notice that the structure of the article weaves together ethnography, literature and analysis, rather than maintaining a strict arrangement of

‘theory, results, discussion’. This follows the philosophical method of those such as Collingwood (1933) and Rawls (1973), in which argument ‘is supported throughout its texture by cross-reference to experience’ (Collingwood 1933, p.51). In the ethical and political context of this paper, such an approach is a necessity, in order to allow the *scholarly* contributions from philosophy and theory and the *grassroots* philosophies of the survivors (what we might think of as the ‘empirical’ content) to progress dialectically together.

Finally, a brief note about language should be made before progressing to the body of the article. Neither ‘therapy’ nor ‘anti-psychiatry’ form unitary or undifferentiated bodies, creating a slippery and often frustrating context in which this discussion takes place. For this reason, from here on the author will use the terms ‘therapy’ or ‘psychotherapy’ to refer generally to the range of non-medical, psychological ‘talking cures’ accessed by people in mental distress as a loosely defined set of practices and beliefs; where specific therapeutic traditions such as counselling or Freudian-derived psychoanalysis are intended, these are indicated separately. ‘Psychiatry’ by contrast refers to the hospital-based medical specialism and related community mental health services; a discussion of ‘anti-psychiatry’ as a social and intellectual movement is reserved for the body of the text. Whilst mapping the field of contention in psychotherapy/psychiatry is not the purpose of this paper (but see Crossley 2006), some typical concerns directed at both psychotherapy and psychiatry include: the ethics of compulsory treatment (Breggin, 2003; Szasz, 1974); the reductionist framework of much psychotherapeutic/psychiatric modelling (Deleuze & Guattari, 1983; Masson, 1993); the technicism and ‘expertism’ that may characterise certain kinds of therapeutic relationships (Smail, 1987; Smeyers, Smith & Standish, 2007); and the proliferation of the psychotherapeutic template to areas previously beyond the remit of health or psychopathology (Furedi, 2004; Sommers & Satel, 2005).

## **Survivors Supporting Survivors: Case study and methods**

To introduce the group (here named ‘Survivors Supporting Survivors’) in more detail, this is a small self-help network run by and for service-users and ex-service-users on the fringes of a deinstitutionalising psychiatric hospital in Northern England. Activities of the network include peer support, campaigning and a reading group on the philosophy of mental distress. The group currently has 23 members (15 female) aged 19-32, all of whom have experience of severe mental distress. Members generally became involved with the group after unsatisfactory experiences with mainstream services, having heard about the network through other patients during periods of in-patient care. Unlike support groups discussed more frequently in the academic literature (e.g. Karp, 1992; Philo, Parr & Burns, 2005), the group has no formal links with service providers or registered patient organisations – an attribute which features rather prominently in its ‘underground’ identity. When asked about their philosophical persuasions, members describe the group as ‘anti-psychiatric’; nevertheless, it is important to note that individual members report various and conflicting personal relations with psychiatry and psychological therapies.

Research methods took the form of an ethnography conducted over a ten month period, made possible due to the author’s own enduring connections and friendships with the network (as such the ethnographic challenge of ‘going native’ was somewhat eased, since the researcher was already an accepted group associate). With the group’s awareness and consent, the author attended weekly meetings as a participant observer for 38 weeks, recording impressions during and after contact. This was supplemented by 20 unstructured interviews in small groups or on a one-to-one basis, which were recorded and transcribed. In total, 17 group members took part in the interviews, with some individuals attending multiple sessions. Approval for all fieldwork was granted by the internal research ethics committee of the author’s institution.

The original purpose of the research was to address a series of questions about listening, which are not addressed in this article. Rather, the discussions about space and place that are reported here arose spontaneously and in the course of several separate moments in the research. The reanalysis of the original dataset to bring out these spatial themes was carried out in discussion with 3 of the original participants who helped to develop and give grounding to the interpretations I present here. All quotations are taken from the original interview transcripts and all names are pseudonyms.

## **The spatiality of ‘psy’ and psychiatric survivorship**

As is well documented in mental health geographies, the history of institutional medical care for the mentally ‘ill’ has often centred on the development of specially circumscribed and rationalised spaces to contain and treat the unhappy and insane. From 19<sup>th</sup> century deliberations about where best to place the proliferating madhouses to contemporary restyling of post-asylum hospital architecture, the spatial organisation of psychiatry has both reflected prevailing views about mental illness and given structure to its treatments (Curtis et al, 2007; Philo, 2004).

Whilst in historical medical geography most attention has been paid to the spatiality of *psychiatry* (predominantly, the asylum and the mental hospital), equally interesting are the micro-spaces of *psychological* treatments. At the origin of psychoanalysis (at least according to conventional renditions of the profession’s development), Freud developed the emblematic couch as central to therapeutic technique. By geographically locating his own chair behind and thus out of sight of the client, Freud believed he could limit undesired psychological transference and enable therapeutic regression (Arehart-Treichel, 2004; Freud, 1913). The couch with its multiple significations (a hospital bed, a lover’s bed, the womb, a surgical table) both enacted and made possible the development of psychodynamic theory at large. In the 1960s, when what we now think of as the counselling movement emerged under the influence of Carl Rogers and others, again it was shifts in the microspatial materialities of the relationship that symbolised change. Contrasting the Freudian-derived ‘dynamic’ analysis client and therapist now sat facing each other, in chairs of equal size in order to foster the ‘core conditions’ of acceptance, empathy and genuineness that Rogers posited were both necessary and sufficient for therapeutic change (Kahn, 1999). Departure from the couch was a means of establishing distance from psychoanalytic method. Yet to look at Rogers’ writing at this time – ‘the therapist is genuine, hiding behind no defensive façade but meeting the client with the feelings which organically he is experiencing... no inner barriers keep the therapist from sensing what it feels like to be the client’ (Rogers, 1961, p.185) – it is clear that seating his clients face-to-face and ‘on a par’ was not just a means to create the core conditions, but actually constituted the core conditions and the new therapeutic relationship themselves. As the British Association of Counsellors put it, ‘this arrangement [comfy chairs, open angles, carefully arranged box of tissues] is so common because in many ways it is perfect’ (Rowan, 1996, p.351); although as I demonstrate next, support for this setup is less unanimous than Rowan appears to suggest.

To shift attention now beyond the settings of psychiatry and psychotherapy, the story of the survivor group is also retold through significant spaces, although these spaces share little with the risk-assessed and planned environments of therapy and psychiatry that I have outlined above. As legend tells it, the group was born in the bathroom of a locked psychiatric ward, where patients began convening ‘in secret’ to talk about aspects of ward life which elsewhere in the hospital were censured. It should be noted here that in psychiatric ward culture, bathrooms have numerous dissident associations, such as places for purging or self-harming. Whilst early members of the group did not meet to engage in these behaviours collectively (just one of the popular anxieties about

unregulated peer-to-peer support), the bathrooms remained preferable to the 'flowery' day rooms where other patients socialised because of the brief privacy they afforded from the surveillance elsewhere on the ward.

As the group grew – in size and also in confidence – it moved out of the wards, as did many of its founding members as they were discharged or transferred to lower security units. During the course of my fieldwork, the group met in varied places: a bike shed on the hospital grounds, darkened bars, grubby fast-food restaurants and, most commonly of all, on the swings or in the burnt-out summerhouse in the city park with its unsavoury reputation as home to the city's vagrants and a popular spot for 'dogging', as outdoor casual sexual encounters are known to their participants. In an observation that was made jokingly by group members throughout the interviews, the most salient features of these venues were often their dubious reputations and unpleasant surroundings compared to the more comfortably furnished environments of conventional psychotherapy and psychiatry.

To an extent, material circumstances necessitate these unconventional venues. The group cannot afford to hire a meeting hall. The hospital holds unhappy memories for members and besides, some of the group's unorthodox practices (harbouring the occasional 'escapee' who had left the hospital grounds without permission, for example) meant that support from formal mental health services was minimal. Yet, from speaking with the survivors, limited access to resources appeared only a *partial* explanation for the group's unusual meeting points:

Becky: The park? Yeah, it's not confined like the hospital. You have some space to think.

Gee: Well it would change us, wouldn't it [to meet in the hospital]? I think we'd have to agree to rules and "talk about how we feel" and become like all the other groups and we know they didn't work for us.

Anna: Yeah, I don't think I'd like that at all. I like it up here [the park]. It's a bit damp and a bit dodgy but it suits us. I don't think somewhere comfy would suit us for some reason. This is sort of who we are.

Without rejecting material explanations, issues such as identity and emotional attunement as expressed here by Becky and the others reveal a connectedness to space that is deeper than spatial marginalisation alone. Echoing the argument with Freud and the couch (above), to the extent that this topophilic relation both enables the group to proceed and distinguishes it from mainstream therapy, the dissidence of the park and other unusual meeting places both define the group and bring it into being.

## **Qualities of an alternative therapeutic space**

Despite the obvious drawbacks and unsightliness of the survivors' meeting points, the alternative spatialities of the survivors are *embraced* by the group as radical and grassroots landscapes of therapy. In what follows, I discuss this 'dissident' connectedness of the survivors to their meeting places (and especially the park) through examination of three interpretive qualities or properties of space that appeared significant throughout the ethnography: (i) spaces of agency and appropriation; (ii) a space in the world; and (iii) an unanalysed and non-technical relation with space. These themes were selected following careful examination of fieldnotes and interview transcripts and were discussed at numerous stages in their development with individual group members – although, inevitably, what follows is only one of a multiple potential arrangements of the data.

### *An appropriated space*

‘It’s ours up here; we’ve claimed it for ourselves’ (Becky, group member).

The spaces of the survivor group – marginal, stigmatised spaces – resemble less the spaces of hospitals or therapy suites than the transgressive landscapes of counterculture and deviance: of vagrants, graffiti artists and a host of hooded skateboarders, to name just a few of the characters who made an appearance in the park during the course of my ethnography. Attending to these other inhabitants of the park offers a way to interpret Becky’s statement (above), and introduces the first of my three themes or ‘properties’ of space. As I frame them here, these are the interrelated qualities of appropriation and action.

A standard critique of psychiatry and psychotherapy highlights the powerlessness and passivity of the patient or client in her physical and symbolic environment (Foucault, 2001; Masson, 1993; Szasz, 1974). In in-patient care, the language with which patients are described (‘when the patient did X, she was admitted/ sectioned/ transferred to the locked ward’) provides a neat illustration of this point: the ‘patient’ is transformed from subject to object in the sentence just as her body is literally shunted around the spaces of the institution. In the talking therapies, whilst the role of the client might be understood in more active terms (as a participant in the therapeutic process, for example), most therapeutic traditions stress the importance of a therapist-maintained space/time boundary to consultation sessions (within this room, at this particular time). Venues are usually (although by no means always) owned or arranged by the therapist; as one group member currently undergoing therapy put it: ‘I’m always on her [the therapist’s] territory, it makes me feel kind of uneasy’.

The skateboarding youth allow a more political and agentic engagement with space to be conceived. Since Lefebvre, this has often been described as an *appropriation* of space – a *taking* of possession, a reclamation, a use *without permission* (Borden, 2001; Childress, 2004; Lefebvre, 1991). The burnt-out summerhouse or cordoned-off roundabout was most definitely an appropriated venue for the survivor group. Appropriating the venue also represented a *symbolic* reclamation of the park from a discourse of unhealthiness to a symbolic landscape of recovery – echoing the change in *self*-perception that many group members experienced when attending meetings, from subjectivities of psychiatric ‘patients’ to psychiatric ‘*survivors*’.

There is much to suggest that aligning the survivors with the skateboarders and not within a medical discourse was important to the group. In interviews, members chose to contrast the skateboarders to the role which ‘mental patients’ were imagined to inhabit, identifying the skateboarders as progressive social engineers. The youths’ rejection of the purpose-built skate park nearby was also recognised in the survivors’ refusal to meet in the more managed environment of the hospital. That the space was *appropriated* thus appeared a way of asserting control: ‘All of us here [emphasis] are like outcasts, but I don’t think that matters because this is our space and there’s no-one else in control of it’ (Kate, group member). It also provided a physical expression of the group’s culture of resilience: ‘In the hospital, they’re trying to keep us in, whereas here, well, they’re trying to keep us out!’ (Jesse, group member).

‘Anti-psychiatric’ philosophy such as Foucault and Szasz, and the insights of the survivor group (above) demonstrate how on the analyst’s couch, or within the therapist’s office, the social relations and power hierarchies of the ‘psy’ industries are able to reproduce themselves. An appropriated space on the other hand redresses inequality; it is radically agentic. In this way, if we take seriously the agenda of the survivor group and its affiliations in the park, then the languages of appropriation and counterculture better describe the survivors than do medicine or therapeutic landscapes.

To end this subsection, I wish briefly to relate this argument back to both therapeutics and a critique of therapy. Bondi (Bondi, 2003; Bondi, 2005; Bondi with Fewell, 2003) has shown that counselling is an inherently spatial practice and that, for some, the physical containment of the therapy room is important in buttressing the metaphorical boundaries of safety and confidentiality, of 'between these four walls'. This article in no way seeks to dismiss that. Yet for others – especially for the members of the survivor group who found the causes of their distress in the *outside world* – the metaphors of 'territory', of 'claiming back' or 'regaining control' appeared more convincing. In these instances, if therapy (as suggested by Bondi with Fewell, 2003) can be understood as a process of *unlocking*, then the appropriated and activ(ist) spaces of the park and other dissident topographies are perhaps the more truly 'therapeutic' environments.

### *A space in the world*

In their classic 'anti-psychiatry' text, *Anti-Oedipus: Capitalism and Schizophrenia*, Deleuze and Guattari (1983) begin their famous attack on the institutions of psychiatry/psychotherapy by proposing 'a breath of fresh air, a relationship with the outside world' (p. 2). Members of 'Survivors' on the park swings or sheltering in the burnt-out summerhouse have taken on board this proposal (or at least provide a way of examining it). The second property of space I draw out here, then, is *a space in the outside world*.

In truth, this interpretation (despite its frequent iteration) is somewhat deceptive. Deleuze and Guattari offered little in the way of *practical* instruction to patients or their clinicians: doubtless to do so would have resembled 'doctor's orders' too closely for their anti-expert sentiments. Instead, to quote again from this famous paragraph: 'a schizophrenic out for a walk is a better *model* than a neurotic lying on the analyst's couch' (p.2, my emphasis). In other words, what Deleuze and Guattari were criticising was the reductive version of psychoanalysis which placed the origin of misery in the psychodramas of the developing individual, exemplified by Freud's concept of the 'Oedipus complex' which the title of their book condemns. Members of the survivor group endorsed this radical social-material account of mental distress emphatically. They rooted their experiences in injustices and injuries embedded in the world itself – in childhood traumas; in conditions of capitalism; in sexism and homophobia and other forms of oppression. To extrapolate from *Anti-Oedipus*, they also imagined *recovery* to not take place in the consulting room but in this world – by collective action, by activism and outreach.

Liz: I don't think it's about changing myself anymore, it's about changing things in the world. I can't change what's already happened, but I might be able to stop it happening to someone else.

Jesse: And that's what 'Survivors' is about. Helping people to get through stuff, helping them to challenge the obstacles in society – that's what outreach means.

'Outreach' happens outside: outside the self, outside the counselling room, beyond the walls of the asylum. 'Doctor's orders' (to go for a stroll, to take some exercise) follows good clinical sense: physicians from Galen onward have noted the physiological benefits of fresh air and exercise on the mind (Turner, 2002), just as environmental psychologists have demonstrated positive clinical outcomes in providing invalids with access to natural design features (daylight, fresh flowers) in a hospital setting (Ulrich, 1997). Yet for the survivor group, 'outside' is also a political affiliation, emblemised by the literal struggles a member might meet in attempting to leave the hospital.



Deleuze and Guattari's vision of the 'schizophrenic on a stroll' (1983, p.2) is a powerful metaphor in emphasising this political and symbolic sense in which 'outside' is understood by the survivors.

Whilst members understood their spaces as belonging to the world, there was an important sense that these were simultaneously spaces 'off the map'. It is no accident that neither I nor my participants have mentioned here care *in the community* or *social inclusion* (two further examples of the spatialisation of mental health care). In line with sentiments reported elsewhere (Baldwin, 1993; Glesson & Kearns, 2001), members were suspicious of the idealised notions of community presented in the 'care in the community' rhetoric. Numerous difficulties in accessing mainstream community settings were reported by group members: a social club recommended by a health professional but which had closed down several months ago; a church where one member was asked to stop attending services because her noisy singing was upsetting the congregation. More generally, it was observed by the survivors that the 'ordinary' spaces of work, education and leisure in the mainstream city were ill-prepared for frank admissions of distress and suffering. By contrast, the social geography of the survivor group was peripheral and marginalised, often in spaces reserved for exiles and runaways. In these contexts, sites 'off the map' provided a space to re-vision care, a transient seizing of communal land for the duration of the weekly meetings.

'Off the map' had multiple meanings for group members. For some, this was a sardonic game of hide-and-seek. One member described with entertaining detail the ideal route from ward to meeting place to attract least attention from 'guards' (security personnel patrolling the car-park) if leaving the grounds without appropriate authorisation. Others more generally referred to escaping the security cameras and relentless ward rounds that punctuated ward space and time. 'Off the map' also meant uncharted territory, the metaphor of a new life 'appearing on the horizon'. For another, this linked back to control and rights in the gaze of an apparently colonising health service:

I like it that the system doesn't really know about us. If they did, they would try to take us over: publish us in their directory of services and make our website have their corporate logo or something. We would become like [a well-known national service-user organisation] where you need referrals from your psychiatrist just to attend, so not really a service-user organisation at all. As it is, no one knows we're here, so we cannot be swallowed into that machine (Sam, group member).

Yet, to return to Deleuze and Guattari, fresh air and unbounded territory also meant 'space to think' or 'getting a new perspective'. This is wilderness therapy – but not the kind marketed to delinquent youths or burnt-out executives (Smeyers et al, 2007). Nor is it the cloistered fresh air permitted in the psychiatric hospital: the courtyard gardens or wards named after mountain peaks or picturesque locations. In this sense, a space 'off the map' highlights an ancient ambivalence that western thought (and therapy by an extension) has had with the outside. Classical philosophy, which was widely conceived less as an intellectual exercise than as a kind of therapy (cp. Nussbaum, 1994) takes place outdoors, but only so far as the *stoa* (covered walkways or porticos) within the city-state: boundaried spaces or restricted freedoms like the hospital gardens or spatio-temporal limits of the counselling hour. For the *far-reaching* claims of Deleuze and Guattari, a less trodden geography is required, in their words: 'in the mountains, amid falling snowflakes, with other gods or without any gods at all' (1983, p. 2).

It should be remembered here that the support group hosts a *discussion group* on the philosophy of mental distress (incidentally, they had recently been reading Deleuze and Guattari at the point of my research, although I do not go so far as to link these observations causally). At the point of my interviews, curiously, the only door sign in the hospital that read 'staff only' was to a small *library*

containing core psychiatric texts for staff and resident medical students (by the time of writing, both the sign and the library had gone due to the ongoing closure the hospital). Given the apparent reluctance of consultants to allow their patients to read, perhaps it was no accident that the discussion group had relocated beyond the walls of the hospital.

### *A non-technical space*

Finally, the transgressive spaces of the survivor group were avowedly *non-technical* spaces – again, a quality which became significant to the survivors because it differentiated the park from the typical spaces of professional practice.

Over generations, psychotherapy has become increasingly technical and prone to knowing itself as a series of abstracted skills and techniques. To understand this point, it is helpful to return temporarily to the historical development of psychoanalysis and the counselling professions. Taking the development of the analytic couch as the first example, in its first published appearance, Freud described the couch as a casual and somewhat expendable feature of the greater project of psychoanalysis:

I must say a word about a certain ceremonial which concerns the position in which the treatment is carried out. I hold to the plan of getting the patient to lie on a sofa while I sit behind him out of his sight. This arrangement has a historical basis; it is the remnant of the hypnotic method out of which psychoanalysis was evolved. But it deserves to be maintained for many reasons. The first is a personal motive [...] I cannot put up with being stared at by other people for eight hours a day. (1913, p.134)

Yet, for the later Freud, the *ceremonial* function of the couch had become a *technique*, from which departures were forbidden. As Jacobson puts it, ‘The use of the couch had moved on a continuum from incidental adjunct, to helpful facilitator, to “without which not”’ (1995, p.305). By his death, the couch and all it stood for was like the intaglios bestowed on his dearest successors, a *sine qua non*: ‘if the patient doesn’t lie on the couch, he isn’t being psychoanalysed’ (Marmor, 1994, p.101).

In the counselling tradition, a second instance of this reification of technique can be observed in the diagramming of the micro-spaces of the counsellor’s room, revealed in many of the numerous counselling training books and manuals available on the market. (There is, incidentally, much resistance to this trend from practicing therapists as well.) To take a somewhat arbitrary example, in a chapter on group work, Eales and Hawkes-Whitehead (1995, p.115) are discussing the material conditions in a hypothetical group therapy session. In the text we are informed ‘a certain amount of street noise intruded on the group this evening’ along with some other minor environmental details. In the right-hand margin, three figures accompany the manuscript: in the first, a floor plan maps the positions of therapist and clients as seated in a circle of chairs. Keith (the counsellor) is seated near the door; Gabinder and Ed (who we are told in the text have been arguing) are by the window, and so on. In the second figure (a ‘structural diagram’), the same group is re-presented conceptually. Gabinder, Ed and the other clients form spokes on an imaginary wheel; our counsellor (despite taking an unobtrusive position in the seating plan) now takes his place in the hub, as the centre of activity. In the final diagram (‘group processes and dynamics’), helpful arrows indicate that it is possible for clients to speak both to Keith and to each other. The chapter, by emphasising just how *ordinary* this is, encourages its readers to reproduce such setups in their own developing practice.

It makes no sense to speak of the meetings in the park in this way. The park has no seating plan and since the group is entirely self-governed and with no facilitating therapist or chair, there is no one member at a conceptual centre. By (the lack of) its physical setup, group dynamics are indeed able to be dynamic: each associate might move from the swings to the bench to the summerhouse several times in a meeting, the larger group might fragment into smaller conversations and people may arrive and leave at different times, but nobody seems to mind.

If, following Foucault, knowledge is power then the significance of this non-technical environment is that it allows a more equal politics of relatedness. When the therapist leads you into the room and gestures, 'take a seat!' – even worse when you are physically removed to the spaces of the locked ward – the power relation (who decides) is already determined. Yet the other aspect of this non-technical kind of space is that it *resisted analysis* (and the reference here is both to psychoanalysis but also the analytic work of research). I have already noted that a highly technical and skills-based understanding of therapy lends itself to approaches in research which seek to split out individual parts in a system and assess their influence on outcome. The counselling training books tend to these needs: the carefully angled chairs, tactful box of tissues, tranquil painting on wall become like a tick-list with which to engineer a perfect therapy room. As argued above, they bring into being the therapy, but they also risk being mistaken for it.

Neither I, nor those participating in my research, found these approaches particularly helpful to understand the support present to the survivor group. Certainly, particular elements of the park could be thought of as beneficial – the fresh air, or lack of surveillance for example – but this was not the sort of knowledge that could be transferred easily (or quickly) back into conventional medical systems. In other words, the implication of this research *could not* be to build a play park in an asylum.

Proponents of the therapeutic landscapes approach have already noted this difficulty, including Gesler himself:

I have tried to persuade the reader of my conviction that there *are* specific steps that can be taken to improve environments in places that will be conducive to health ... The danger, of course, is that ... one could come away from this book with the impression that all one has to do is implement a specific design feature such as plant a garden in a hospital courtyard and all will be well. Of course that is not true. (Gesler, 2003, p.110-11)

Yet, ultimately, Gesler comes down on the side of technique and top-down implementation: in the concluding paragraphs, 'Let us implement design features and then evaluate them ... I suggest one can think in terms of three processes: conceptualization, implementation and evaluation' (Gesler, 2003, p.111-13). Whilst Gesler does a commendable job in convincing the reader this may be possible in the specific contexts he discusses, the *institutionalism* of the process he proposes seems most alien to the emerging landscapes of the survivors.

This point, I think, also suggests some thoughts on how *research* into 'alternative' therapeutic landscapes might be conducted. When I was discussing my research with the survivor group, one member warned me that if you cut open the songbird to find why he is singing, you kill the song. This does not necessarily mean that research into dissident topophilias cannot be attempted, but rather that the peace and 'anti-psychiatric' wellbeing of the survivor group demands a different kind of knowing. In terms of research 'methods', this is research that is slow and holistic rather than analytic and driven by pressures for 'best evidence'. It is a kind of research which gives space to

people to explore their own understandings of place before chopping out components into discourses of efficiency; a research that waits and listens.

## **Conclusions: Mapping the space of psychiatric survivorship**

The final paragraphs of this article are indebted to a friend and practising counsellor who on reading an earlier draft of this paper exclaimed at some critiques of therapy, 'whatever we do, they won't like it!' Doubtless this will ring true for other readers who are puzzled by the 'contrariness' of the survivors' choices of venue (or else who attribute them only to insanity). As a final task I shall attempt to address some of these reservations.

As I have discussed extensively in this paper, much social science research has sought to examine the affective connectedness between people, place and wellbeing. To recap two of the concepts I have worked with (each with a distinct theoretical heritage), these might be described variously as *topophilias* or *therapeutic landscapes*. Whilst both constructs have proved valuable in interpreting the spatiality of the survivor group, frameworks such as these render the survivor group atypical or dissident – not least because the research they proffer takes as its core examples the very landscapes which the survivor group rejected. At the heart of this is an *aesthetic* of space: it is too frequently assumed that a *pleasant* environment (a clean and planned and congenial one) is best for recovery; progressive attempts by planners to create such landscapes in clinical settings appear as ethically sound as they are commonsensical. Yet the survivor group demonstrates a different aesthetic:

'The park understands me. It suits the lot of us, being a bit outcast and dejected and vandalised like us in some ways' (Sam, group member).

To turn away from *topophilias* or *therapeutic landscapes* momentarily, a final term, this time from literary criticism, might be helpful here. In literature, it is well understood that therapeutic places are not always the most comfortable ones. Unhappy characters are wont to roam wild moors, explore the darker side of town or wander aimlessly in the rain as ways to process their anguish. The (em)pathetic fallacy – the anthropomorphic symmetry between the natural elements and a character's emotional state – is the literary device which both conveys this to the reader, and allows the protagonist to continue on his psychic journey. In terms of the rejected niceties of the therapy room, Clewell could not put it better when she describes this as 'consolation refused' (Clewell, 2004). A misjudged offer of comfort (the 'hideous flowery furnishings' in the hospital dayroom, perhaps) trivialises injury and further alienates the injured. A pathetic fallacy (which is not actually so false) is instead a landscape that can connect to the individual in the state they are in; as Sam suggests above, a place which 'suits' the mood.

The kind of clearing the head that occurs in the pathetic fallacy is not necessarily easy or enjoyable, yet it is well understood that the connectedness between human and environment is part of the healing process. Characters come back storm-beaten and lonely, but they feel better; often they are also better people. As the timeless example, we remember King Lear's revelation in the storm:

When the rain came to wet me once and the wind to / make me chatter, when the thunder would not peace / at my bidding, there I found 'em, there I smelt 'em out (*King Lear* 4, vi, 100-102).

George Williams writes that 'the tragic world is a kind of chaos: the disorder within the soul is projected into the larger world. The storm is thus the disorder or purgative necessary to the order or

health of the king. It can only be meaningful if taken in this sense' (G. Williams, 1951, p.60). The audience understands intuitively that a cloudless sky (or a carefully arranged counselling room) could not have redeemed the king; furthermore, most of us can apply this in some respect to our own emotional landscape. The disordered setting of Lear or the dissident landscape of the survivor group bear little in common with the manicured environments of the talking therapies or medical psychiatry. Yet, in understanding that recovery is often a painful and always an unmapped process of 'working through', the pathetic fallacy helps to show that these less-than-comfortable environments are in no way 'mad' but demonstrate both psychological congruence and emotionally intelligibility.

To conclude, psychiatric 'survivors' are a diverse group of people who find help and encouragement through various means. 'Anti-psychiatry' comes in many versions and with many discontents as its target (Crossley 2006). No doubt many other patients outside of the group would be horrified to find what the survivors were up to; likewise, individual members of the group maintained diverse relations with the ideologies of psychiatry and its practices. It would also be a mistake to assume that the dissident landscapes of the survivor group negated the nostalgia that patients and ex-patients have reported towards their hospitals, as places of refuge or in the traditional sense asylum (Parr, Philo, & Burns, 2003; Pinfold, 2000). Of the minority of group members who reported 'escaping' to attend meetings, it is interesting that all of them returned voluntarily to the wards when they were ready. With Deleuze and Guattari, perhaps they had only 'gone for a stroll'.

The survivor group, however muddled, however much a minority, is an important case for therapeutic landscapes approaches. As I have argued, radically alternative and subversive forms of support such as the survivor group have remained 'off the map' of social science and health research, invoking an ethics of exclusion. Yet perversely, as shown by the survivors, the 'unmappable' quality of this landscape constitutes an important part of what makes the group function. Acknowledging the survivor group and the other people who through choice inhabit the dissident spaces of the parks and grubby cafes provides a richer understanding of what it means to be 'therapeutic' and who can give therapy to whom. Attending to the group and the survivorship it displays is also one way of identifying a rift in the growing hegemony of 'evidence-base', that only the researched, the mapped and the scheduled roads to recovery can be considered to be 'what works'.

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